City of NORFOLK

C: Dirs., Human Resources and
Budget and Strategic Planning

To the Honorable Council
City of Norfolk, Virginia

October 13, 2015

From: Sabrina Joy-Hogg, Deputy City Manager

Subject: Healthcare Plan Offering Ordinance

Reviewed: Wynter C. Benda, Deputy City Manager

Ward/Superward: Citywide

Approved: Marcus D. Jones, City Manager

Item Number: **R-26**

I. **Recommendation:** Adopt Ordinance

II. **Applicant:** City of Norfolk

III. **Description:**
This agenda item authorizes the city to move forward with the recommended healthcare plans effective January 1, 2016.

IV. **Analysis**
The city consistently evaluates health benefit offerings and proactively manages the rising cost of healthcare. As result of this constant monitoring, the City was able to avoid $6.0 million in cost by transitioning from a fully-insured model to a self-administered model.

There are many changes required as a result of the implementation of the Affordable Care Act (ACA). In 2018, an Excise (Cadillac) Tax will be imposed on all employers providing healthcare. As a result of this tax, employers will be charged 40 percent based on the value of the healthcare plan offerings. Preliminary estimates for the City of Norfolk indicate that the city will be subject to pay this tax if plan design changes are not made.

As a result, gradual changes are needed over the next two years to mitigate the impact of the tax payment. For the upcoming benefit plan year, the city has done the following to mitigate the impact:

- Added an additional health savings plan option
- Implemented annual plan design changes
- Renamed existing plans to focus employees on options

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V. Financial Impact

The Approved FY 2016 Budget incorporated these anticipated plan changes and appropriated funds for a planned seven percent increase.

VI. Environmental

N/A

VII. Community Outreach/Notification

N/A

VIII. Board/Commission Action

N/A

IX. Coordination/Outreach

This letter and ordinance have been coordinated with the Department of Human Resources, Office of Budget and Strategic Planning and the City Attorney's Office.

Form and Correctness Approved:

By _____
Office of the City Attorney

Contents Approved:

By _____
DEPT. Human Resources

Pursuant to Section 72 of the City Charter, I hereby certify that the money required for this item is in the city treasury to the credit of the fund from which it is drawn and not appropriated for any other purpose.

$ N/A — various
Account

_____ — 10/12/15
Acting Director of Finance — Date

NORFOLK, VIRGINIA

ORDINANCE No.

AN ORDINANCE APPROVING THE 2016 OFFICER AND EMPLOYEE HEALTH INSURANCE PLANS, THE EMPLOYER AND EMPLOYEE CONTRIBUTION RATES AND AUTHORIZING THE EXPENDITURE OF A SUM SUFFICIENT FROM THE HEALTH CARE FUND HERETOFORE APPRORIATED.

BE IT ORDAINED, by the Council of the City of Norfolk:

Section 1:- That effective for the 2016 year, the three (3) plans whose summaries are attached and whose benefits and costs are described in Attachment A are approved for each officer and employee to elect for their health insurance benefits and the City Manager and City Attorney are authorized to negotiate the amendments necessary to the Service Agreement with Optima Health.

Section 2:- That effective January 1, 2016, a one-time lump sum Health Savings Account contribution of Five Hundred Dollars ($500) for individual coverage and One Thousand Dollars ($1,000) for spousal and family coverage will be made for each member choosing to enroll in Plan A.

Section 3:- That the table below sets out the 2016 Monthly Medical Premium Rates.

Plan A	**WBA Completed, Employee Share**	**No WBA Completed, Employee Share**	**City's Share WBA Completed**	**City's Share No WBA**
Employee Only	$15	$25	$507	$497
Employee + Children	$111	$121	$725	$715
Employee + Spouse	$146	$156	$898	$888
Employee + Family	$287	$297	$1,387	$1,377
Married Employees**	$105	$115	$1,569	$1,559

Plan B	WBA Completed	No WBA Completed	City's Share WBA Completed	City's Share No WBA
Employee Only	$45	$55	$484	$474
Employee + Children	$185	$195	$678	$668
Employee + Spouse	$235	$245	$843	$833
Employee + Family	$403	$413	$1,324	$1,314
Married Employees**	$170	$180	$1,557	$1,547

Plan C	WBA Completed	No WBA Completed	City's Share WBA Completed	City's Share No WBA
Employee Only	$110	$120	$453	$443
Employee + Children	$275	$285	$627	$617
Employee + Spouse	$400	$410	$727	$717
Employee + Family	$640	$650	$1,166	$1,156
Married Employees**	$358	$368	$1,448	$1,438

**Married Employees = both spouses are employed by City of Norfolk

Section 4:- That a sum sufficient is authorized to be expended in payment of the coverages and third party administration from the Healthcare Fund heretofore appropriated.

Section 5:- That the City's contribution to such Health Savings Accounts will be prorated based on the hire date for eligible participating employees.

Section 6:- That the Health Savings Account eligibility and contributions are governed and regulated by the Internal Revenue Code.

Section 7:- That this ordinance shall be in effect from and after its adoption.

ATTACHMENT A

MEDICAL BENEFIT COST COMPARISON 2015/2016

	Current 2015 Plans		2016 Plans		
	Plus Plan POS	Value Plan POS	Plan A	Plan B	Plan C
Deductible	$250/$500	$500/$1,000	$1,500/$3000 (non-embedded)	$1,000/$2,000	$500/$1,000
H.S.A. Funding	N/A	N/A	$500/$1,000	N/A	N/A
Out of Pocket Max	$3,000/$6,000	$4,000/$8,000	(embedded)	$4,500/$9,000	$4,000/$8,000
PCP Visit	$20 copay	$25 copay	20% after deductible	$25 copay	$25 copay
Preventive Visit	100%	100%	100%	100%	100%
Specialist Visit	$40 copay	$50 copay	20% after deductible	$50 copay	$50 copay
Diagnostic (X-ray, blood work)	20% after deductible	20% after deductible	20% after deductible	15% after deductible	10% after deductible
Imaging (CT/PET, MRI)	20% after deductible	20% after deductible	20% after deductible	15% after deductible	10% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	20% after deductible	15% after deductible	10% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	20% after deductible	15% after deductible	10% after deductible
Maternity Care	20% after deductible	20% after deductible	20% after deductible	$350 global copay	$350 global copay
Retail Pharmacy:					
Generic	$10	$10	$10 after deductible	$10	$10
Formulary	$30	$30	$30 after deductible	$30	$30
Non-Formulary	$60	$60	$60 after deductible	$60	$60
Speciality	$60	$60	$60 after deductible	$60	$60

PLAN A

Norfolk Consortium 2016

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Summary Plan Document, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists the percent Coinsurance the Plan will pay for In Network benefits from Plan Providers. The other column lists Your percent Coinsurance the Plan will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Summary Plan Document carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year[3]	$1,500 per Person (if individual coverage only) $3,000 per Family (all dependent tiers)	$3,000 per Person (if individual coverage only) $6,000 per Family (all dependent tiers)
Maximum Out-of-Pocket Limit per Calendar Year	$5,000 per Person[4] $10,000 per Family[4]	$6,500 per Person[5] $13,000 per Family[5]

PHYSICIAN SERVICES

Your Coinsurance applies to Covered Services done during an office visit. You will pay additional Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery**[6].

Physician Office Visits	**In-Network Benefits Coinsurance**[2]	**Out-of-Network Benefits Coinsurances**[2]
Primary Care Physician (PCP) Office Visit	After Deductible You Pay 20%	After Deductible You Pay 50%
Specialist Office Visit	After Deductible You Pay 20%	After Deductible You Pay 50%
MD Live	After Deductible You Pay 20%	
Vaccines and Immunotherapeutic Agents This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 50%	After Deductible You Pay 50%
Preventive Care [10,11]	**In-Network Benefits/Coinsurance**[2]	**Out-of-Network Benefits Coinsurances**[2]
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears** [11] **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 50%

OUTPATIENT THERAPY AND REHABILITATION SERVICES		
You Pay Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.		
Short Term Therapy Services[7]	**In-Network Benefits Coinsurance**[2]	**Out-of-Network Benefits Coinsurances**[2]
Physical Therapy **Occupational Therapy** **Pre-Authorization is required.**[6] Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Coinsurance applies at any place of service.	After Deductible You Pay 20% per visit	After Deductible You Pay 50% per visit
Speech Therapy **Pre-Authorization is required.**[6] Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Coinsurance applies at any place of service.	After Deductible You Pay 20% per visit	After Deductible You Pay 50% per visit
Short Term Rehabilitation Services[7]	**In-Network Benefits Coinsurance**[2]	**Out-of-Network Benefits Coinsurances**[2]
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[6] Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Coinsurance applies at any place of service.	After Deductible You Pay 20% per visit	After Deductible You Pay 50% per visit
Other Outpatient Treatments	**In-Network Benefits Coinsurance**[2]	**Out-of-Network Benefits Coinsurances**[2]
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	After Deductible You Pay 20% per visit	After Deductible You Pay 50% per visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Coinsurance.	After Deductible You Pay 20%	After Deductible You Pay 50%

OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Dialysis Services Coinsurance applies at any place of service.	After Deductible You Pay 20% per visit	After Deductible You Pay 50% per visit
OUTPATIENT SURGERY		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay 20%	After Deductible You Pay 50%
OUTPATIENT DIAGNOSTIC PROCEDURES		
Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Diagnostic Procedures	After Deductible You Pay 20%	After Deductible You Pay 50%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 20%	After Deductible You Pay 50%
Lab Work	After Deductible You Pay 20%	After Deductible You Pay 50%
OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Pre-Authorization is required for all procedures except Sleep Studies, MRS, SPECT and Nuclear Cardiology.[6]** Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You Pay 20%	After Deductible You Pay 50%
MATERNITY CARE		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.[6]** Includes prenatal, delivery, postpartum services, and home health visits. Coinsurance is in addition to any applicable inpatient hospital Coinsurance.	After Deductible You Pay 20%	After Deductible You Pay 50%

INPATIENT SERVICES		
Inpatient Services	**In-Network Benefits Coinsurance[2]**	**Out-of-Network Benefits Coinsurances[2]**
Inpatient Hospital Services **Pre-Authorization is required.[6]** **Transplants are covered at contracted facilities only.**	After Deductible You Pay 20%	After Deductible You Pay 50%
Skilled Nursing Facilities/Services[7] **Pre-Authorization is required.[6]** Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 20%	After Deductible You Pay 50%
AMBULANCE SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Ambulance Services[9] **Pre-Authorization is required for non-emergent transportation only.[6]** Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Coinsurance is applied per transport each way.	After Deductible You Pay 20%	After Deductible You Pay 20%
EMERGENCY SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Emergency Services [2, 9] **Pre-Authorization is <u>not</u> required.** Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible You Pay 20%	After Deductible You Pay 20%
URGENT CARE CENTER SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Urgent Care Services[9] **Pre-Authorization is <u>not</u> required.** Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Coinsurance.	After Deductible You Pay 20%	After Deductible You Pay 50%

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. **Also includes services for Biologically Based Mental Illnesses** for the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.		
Mental/Behavioral Health/Substance Use Disorder	**In-Network Benefits Coinsurance[2]**	**Out-of-Network Benefits Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]**	After Deductible You Pay 20%	After Deductible You Pay 50%
Outpatient Office Visits **Pre-Authorization is required for partial hospitalization services, intensive outpatient program (IOP) services, and electro-convulsive therapy [6]**	After Deductible You Pay 20%	After Deductible You Pay 50%
OTHER COVERED SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurances[2]**
Prosthetics and Components **Pre-Authorization is required.[6]** Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.[7] "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible You Pay 20%	After Deductible You Pay 50%

Autism Spectrum Disorder **Pre-Authorization is required.**[6] Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder in children from age two through 10. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) psychiatric care, (iii) psychological care, (iv) therapeutic care, and (v) **applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied behavioral analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000.**[6]	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, and Coinsurance factors, and benefit year maximum for Deductibles and Coinsurance factors. Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Coinsurance factors, and benefit year maximum for Deductibles and Coinsurance factors. Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.
Clinical Trials **Pre-Authorization is required.**[6] Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.

OTHER COVERED SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Diabetic Supplies and Equipment Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating EyeMed Provider at the applicable office visit Coinsurance amount.	You Pay 20% for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. No Coinsurance for insulin pumps. No Coinsurance for outpatient self-management training and education, including medical nutritional therapy.	You Pay 50%
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.[6]** **Pre-Authorization is required for all rental items.[6]** **Pre-Authorization is required for repair and replacement.[6]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	After Deductible You Pay 20%	After Deductible You Pay 50%
Early Intervention Services **Pre-Authorization is required.[6]** Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of service.	Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of service.

OTHER COVERED SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Home Health Care Skilled Services[7] **Pre-Authorization is required.[6]** Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.[7] You will pay a separate outpatient therapy Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible Covered at 100%	After Deductible You Pay 50%
Hospice Care **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 50%
Preventive Vision Services[7] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.	Covered at 100% Contact lens examinations require the eye examination Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to $30 for an eye examination only. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit.
Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission.	Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible or Coinsurance amounts will not exceed the Deductible or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.	Members are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible or Coinsurance amounts will not exceed the Deductible or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.

PRESCRIPTION DRUG BENEFIT	
Pharmacy Out-of-Pocket Maximum	**$1500 per individual/$3000 per family**
More information about **prescription drug coverage** is available at www.express-scripts.com. Insulin, syringes, and needles are covered under the Prescription Drug Benefit. Preventive drugs listed on ESI's Standard Plus Medication list are covered without the deductible.	**For each prescription or refill:** Tier 1 - $10 Copayment[AD] Tier 2 - $30 Copayment[AD] Tier 3 – $60 Copayment[AD] Tier 4 – $60 Copayment[AD] **For Mail Order:** Tier 1 - $20 Copayment[AD] Tier 2 - $60 Copayment[AD] Tier 3 – $120 Copayment[AD] Tier 4 - $120 Copayment[AD]

NOTES

All benefits are subject to the terms and conditions in the *Summary Plan Document* (SPD). Words that are capitalized are defined terms listed in the Definitions section of the SPD.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your SPD for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your SPD in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

   Allowable Charge is the amount Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima Health or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

   Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits. All other Covered Services received from Non-Plan Providers will be Covered under Your Out-of-Network benefits.

   When You use Out-of Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. If You have individual coverage You must satisfy the individual member Deductible before Coverage begins. If You have family coverage You must satisfy the family coverage Deductible. **Your Plan has a non-embedded individual deductible. Non-embedded means if one covered family member meets the individual member deductible his or her benefits will not begin until the entire family deductible is satisfied. Once the total family coverage deductible is met benefits are available for all covered family members.** A Plan may have separate individual and family Deductibles for In-Network Covered Services and for Out-of-Network Services. Deductibles will not be reimbursed under the Plan. The Deductible does not apply to Preventive Care Visits and Screenings from In-Network Plan Providers. Amounts applied to Your In-Network Deductible will apply toward Your Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to Your Out-of-Network Deductible will apply toward Your Out-of-Network Maximum Out of Pocket Limit. Should the Federal Government adjust the Deductible for high Deductible health plans as defined by the Internal Revenue Service, the Deductible amount in the Policy will be adjusted accordingly.

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, s and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Balance billing amounts from Non-Plan Providers;
    4. Premium amounts;
    5. Amounts You pay as a penalty for failure to comply with the Plan's Pre-Authorization procedures;
    6. Except for Emergency Services, amounts You pay for Out-of-Network Services;

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In- Network Benefits. Deductibles, s and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductible, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Amounts You pay for In- Network Benefits;
    4. Amounts You pay for Vision care;
    5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction,
    6. Amounts You pay as a penalty for failure to comply with the Plan's Pre-Authorization procedures;
    7. Amounts applied to Your In-Network Deductible;
    8. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
    9. Premium amounts

6. This benefit requires Pre Authorization before You receive services. Your benefits for Covered Services may be reduced or denied if You do not comply with the Plan's Pre-Authorization requirements. The Plan may also apply a penalty of up to $500 to any benefits paid for Covered Services if You do not comply with the Plan's Pre-Authorization requirements.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles and Coinsurance factors and that are no less favorable than for physical Illness generally.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Deductibles or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider

10. Preventive Care includes the services listed below. You may be responsible for office visit Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

    1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

    2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

    3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

    4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

    - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
    - **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
    - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
    - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
    - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
    - **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
    - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
    - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

PLAN B

Norfolk Consortium 2016

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Summary Plan Document, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance the Plan will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance the Plan will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Summary Plan Document carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year[3]	$1,000 per Person $2,000 per Family	$2,000 per Person $4,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	$4,500 per Person[4] $9,000 per Family[4]	$5,500 per Person[5] $11,000 per Family[5]

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery**[6].

Physician Office Visits	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Primary Care Physician (PCP) Office Visit	You Pay $25	After Deductible You Pay 50%
Specialist Office Visit	You Pay $50	After Deductible You Pay 50%
MD Live Virtual Consult Visits	You Pay $15	
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 50%	After Deductible You Pay 50%
Preventive Care [10,11]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears** [11] **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 50%

OUTPATIENT THERAPY AND REHABILITATION SERVICES		
You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.		
Short Term Therapy Services[1]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Physical Therapy **Occupational Therapy** **Pre-Authorization is required.**[6] Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 15% per visit	After Deductible You Pay 50% per visit
Speech Therapy **Pre-Authorization is required.**[6] Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 15% per visit	After Deductible You Pay 50% per visit
Short Term Rehabilitation Services[1]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[6] Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 15% per visit	After Deductible You Pay 50% per visit
Other Outpatient Treatments	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	You Pay $25 per PCP office visit You Pay $50 per Specialist office visit After Deductible You Pay 15% per outpatient facility visit	After Deductible You Pay 50% per visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible You Pay 15%	After Deductible You Pay 50%

OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 15% per visit	After Deductible You Pay 50% per visit
OUTPATIENT SURGERY		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay 15%	After Deductible You Pay 50%
OUTPATIENT DIAGNOSTIC PROCEDURES		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Diagnostic Procedures	After Deductible You Pay 15%	After Deductible You Pay 50%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 15%	After Deductible You Pay 50%
Lab Work	After Deductible You Pay 15%	After Deductible You Pay 50%
OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Pre-Authorization is required for all procedures except Sleep Studies, MRS, SPECT and Nuclear Cardiology.[6]** Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You Pay 15%	After Deductible You Pay 50%
MATERNITY CARE		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.[6]** Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	You Pay $350 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 50%

INPATIENT SERVICES		
Inpatient Services	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Hospital Services Pre-Authorization is required.[6] Transplants are covered at contracted facilities only.	After Deductible You Pay 15%	After Deductible You Pay 50%
Skilled Nursing Facilities/Services[7] Pre-Authorization is required.[6] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 15%	After Deductible You Pay 50%
AMBULANCE SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Ambulance Services[9] Pre-Authorization is required for non-emergent transportation only.[6] Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You Pay 15%	After Deductible You Pay 15%
EMERGENCY SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Emergency Services [2, 9] Pre-Authorization is not required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible You Pay 15%	After Deductible You Pay 15%
URGENT CARE CENTER SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Urgent Care Services[9] Pre-Authorization is not required. Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	You Pay $50	After Deductible You Pay 50%

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. **Also includes services for Biologically Based Mental Illnesses** for the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.		
Mental/Behavioral Health/Substance Use Disorder	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]**	After Deductible You Pay 15%	After Deductible You Pay 50%
Outpatient Office Visits **Pre-Authorization is required for partial hospitalization services, intensive outpatient program (IOP) services, and electro-convulsive therapy[6]**	You Pay $25	After Deductible You Pay 50%
OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Prosthetics and Components **Pre-Authorization is required.[6]** Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.[7] "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible You Pay 15%	After Deductible You Pay 50%

Autism Spectrum Disorder Pre-Authorization is required.[6] Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder in children from age two through 10. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) psychiatric care, (iii) psychological care, (iv) therapeutic care, and (v) **applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied behavioral analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000.**[6]	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Clinical Trials **Pre-Authorization is required.[6]** Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.
Diabetic Supplies and Equipment Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating EyeMed Provider at the applicable office visit Copayment or Coinsurance amount.	You Pay 15% for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. No Copayment or Coinsurance for insulin pumps. No Copayment or Coinsurance for outpatient self-management training and education, including medical nutritional therapy.	After Deductible You Pay 50%
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.[6]** **Pre-Authorization is required for all rental items.[6]** **Pre-Authorization is required for repair and replacement.[6]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	After Deductible You Pay 15%	After Deductible You Pay 50%
Early Intervention Services **Pre-Authorization is required.[6]** Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Home Health Care Skilled Services[7] **Pre-Authorization is required.[6]** Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.[7] You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible Covered at 100%	After Deductible You Pay 50%
Hospice Care **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 50%
Preventive Vision Services[7] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.	Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit unless services are considered an Essential Health Benefit (EHB) for children.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to $30 for an eye examination only. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit.
Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.

PRESCRIPTION DRUG BENEFIT	
Pharmacy Out-of-Pocket Maximum	**$2100 per individual/$4200 per family**
More information about **prescription drug coverage** is available at www.express-scripts.com. Insulin, syringes, and needles are covered under the Prescription Drug Benefit.	**For each prescription or refill:** Tier 1 - $10 Copayment Tier 2 - $30 Copayment Tier 3 – $60 Copayment Tier 4 – $60 Copayment **For Mail Order:** Tier 1 - $20 Copayment Tier 2 - $60 Copayment Tier 3 – $120 Copayment Tier 4 - $120 Copayment

NOTES

All benefits are subject to the terms and conditions in the *Summary Plan Document* (SPD). Words that are capitalized are defined terms listed in the Definitions section of the SPD.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your SPD for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your SPD in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

   Allowable Charge is the amount Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima Health or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

   Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits. All other Covered Services received from Non-Plan Providers will be Covered under Your Out-of-Network benefits.

   When You use Out-of Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to an Out-of-Network Deductible will apply toward the Plan's Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Preventive Care Visits and Screenings You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles will not be reimbursed under the Plan. Any part of the calendar year Deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year.

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Balance billing amounts from Non-Plan Providers;
    4. Premium amounts;
    5. Amounts You pay as a penalty for failure to comply with the Plan's Pre-Authorization procedures;
    6. Except for Emergency Services, amounts You pay for Out-of-Network Services;
    7. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
        i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children;
        ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered an Essential Health Benefit (EHB) for children;

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In- Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductible, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Amounts You pay for In- Network Benefits;
    4. Amounts You pay for Vision care;
    5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction,
    6. Amounts You pay as a penalty for failure to comply with the Plan's Pre-Authorization procedures;
    7. Amounts applied to Your In-Network Deductible;
    8. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
    9. Premium amounts

6. This benefit requires Pre Authorization before You receive services. Your benefits for Covered Services may be reduced or denied if You do not comply with the Plan's Pre-Authorization requirements. The Plan may also apply a penalty of up to $500 to any benefits paid for Covered Services if You do not comply with the Plan's Pre-Authorization requirements.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

    1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

    2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

    3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

    4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

    - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
    - **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
    - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
    - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
    - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
    - **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
    - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
    - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.

PLAN C

Norfolk Consortium 2016

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Summary Plan Document, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance the Plan will pay for In Network benefits from Plan Providers. The other column lists Your Copayment or the percent Coinsurance the Plan will pay for Out of Network benefits from Non-Plan Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-authorization, Covered Services, and Non-Covered Services please read Your entire Summary Plan Document carefully.

DEDUCTIBLES, MAXIMUM OUT-OF-POCKET LIMIT

	In-Network Benefits	Out-of-Network Benefits
Deductibles per Calendar Year[3]	$500 per Person $1,000 per Family	$1,000 per Person $2,000 per Family
Maximum Out-of-Pocket Limit per Calendar Year	$4,000 per Person[4] $8,000 per Family[4]	$4,500 per Person[5] $9,000 per Family[5]

PHYSICIAN SERVICES

Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapy and rehabilitation services, injectable and infused medications, outpatient advanced imaging procedures, and sleep studies done during an office visit. **Pre-Authorization is required for in-office surgery**[6].

Physician Office Visits	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Primary Care Physician (PCP) Office Visit	You Pay $25	After Deductible You Pay 50%
Specialist Office Visit	You Pay $50	After Deductible You Pay 50%
MD Live Virtual Consult Visits	You Pay $15	
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	After Deductible You Pay 50%	After Deductible You Pay 50%
Preventive Care [10,11]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Routine Annual Physical Exams **Well Baby Exams** **Annual GYN Exams and Pap Smears** [11] **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Women's Preventive Services**	Covered at 100%	After Deductible You Pay 50%

OUTPATIENT THERAPY AND REHABILITATION SERVICES		
You Pay a Copayment or Coinsurance amount for Therapy and Rehabilitation services done in a Physician's office, a free-standing outpatient facility, a hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit.		
Short Term Therapy Services[7]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Physical Therapy **Occupational Therapy** **Pre-Authorization is required.**[6] Physical and Occupational Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 50% per visit
Speech Therapy **Pre-Authorization is required.**[6] Speech Therapy is limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 50% per visit
Short Term Rehabilitation Services[7]	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[6] Services are limited to a maximum combined benefit with In-Network and Out-of-Network benefits and for all places of service of 30 visits per calendar year.[7] Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 50% per visit
Other Outpatient Treatments	**In-Network Benefits Copayments/Coinsurance**[2]	**Out-of-Network Benefits Copayments/Coinsurances**[2]
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	You Pay $25 per PCP office visit You Pay $50 per Specialist office visit After Deductible You Pay 10% per outpatient facility visit	After Deductible You Pay 50% per visit
Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.	After Deductible You Pay 10%	After Deductible You Pay 50%

OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Dialysis Services Copayment or Coinsurance applies at any place of service.	After Deductible You Pay 10% per visit	After Deductible You Pay 50% per visit
OUTPATIENT SURGERY		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Outpatient Surgery **Pre-Authorization is required.[6]** Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.	After Deductible You Pay 10%	After Deductible You Pay 50%
OUTPATIENT DIAGNOSTIC PROCEDURES		
Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Diagnostic Procedures	After Deductible You Pay 10%	After Deductible You Pay 50%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 10%	After Deductible You Pay 50%
Lab Work	After Deductible You Pay 10%	After Deductible You Pay 50%
OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Pre-Authorization is required for all procedures except Sleep Studies, MRS, SPECT and Nuclear Cardiology.[6]** Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	After Deductible You Pay 10%	After Deductible You Pay 50%
MATERNITY CARE		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Maternity Care [8, 10,11] **Pre-Authorization is required for prenatal services.[6]** Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance.	You Pay $350 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 50%

INPATIENT SERVICES		
Inpatient Services	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Hospital Services Pre-Authorization is required.[6] Transplants are covered at contracted facilities only.	After Deductible You Pay 10%	After Deductible You Pay 50%
Skilled Nursing Facilities/Services[7] Pre-Authorization is required.[6] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined with In-Network and Out-of-Network benefits per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.[7]	After Deductible You Pay 10%	After Deductible You Pay 50%
AMBULANCE SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Ambulance Services[9] Pre-Authorization is required for non-emergent transportation only.[6] Includes air and ground ambulance for emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Copayment or Coinsurance is applied per transport each way.	After Deductible You Pay 10%	After Deductible You Pay 10%
EMERGENCY SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Emergency Services [2, 9] Pre-Authorization is <u>not</u> required. Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After Deductible You Pay 10%	After Deductible You Pay 10%
URGENT CARE CENTER SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Urgent Care Services[9] Pre-Authorization is <u>not</u> required. Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay an Emergency Services Copayment or Coinsurance.	You Pay $50	After Deductible You Pay 50%

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. **Also includes services for Biologically Based Mental Illnesses** for the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.		
Mental/Behavioral Health/Substance Use Disorder	**In-Network Benefits Copayments/Coinsurance[2]**	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Inpatient Services **Pre-Authorization is required[6]**	After Deductible You Pay 10%	After Deductible You Pay 50%
Outpatient Office Visits **Pre-Authorization is required for partial hospitalization services, intensive outpatient program (IOP) services, and electro-convulsive therapy[6]**	You Pay $25	After Deductible You Pay 50%
OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurances[2]**
Prosthetics and Components **Pre-Authorization is required.[6]** Services include coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components.[7] "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to enrollee neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After Deductible You Pay 10%	After Deductible You Pay 50%

Autism Spectrum Disorder Pre-Authorization is required.[6] Covered Services include "diagnosis" and "treatment" of Autism Spectrum Disorder in children from age two through 10. "Autism Spectrum Disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. "Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) psychiatric care, (iii) psychological care, (iv) therapeutic care, and (v) **applied behavioral analysis when provided or supervised by a board certified behavioral analyst licensed by the Board of Medicine.** "Applied behavioral analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. **Coverage for applied behavioral analysis under this benefit is limited to an annual maximum benefit of $35,000.**[6]	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	Coverage for Autism Spectrum Disorder will not be subject to any visit limits, and will be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining Deductibles, lifetime dollar limits, Copayment and Coinsurance factors, and benefit year maximum for Deductibles and Copayment and Coinsurance factors. Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Clinical Trials **Pre-Authorization is required.[6]** Coverage of routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service listed on the Face Sheet or Schedule of Benefits.
Diabetic Supplies and Equipment Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. An annual diabetic eye exam is covered from an Optima Health Plan Provider or a participating EyeMed Provider at the applicable office visit Copayment or Coinsurance amount.	You Pay 10% for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. No Copayment or Coinsurance for insulin pumps. No Copayment or Coinsurance for outpatient self-management training and education, including medical nutritional therapy.	After Deductible You Pay 50%
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.[6]** **Pre-Authorization is required for all rental items.[6]** **Pre-Authorization is required for repair and replacement.[6]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement.	After Deductible You Pay 10%	After Deductible You Pay 50%
Early Intervention Services **Pre-Authorization is required.[6]** Covered for Dependents from birth to age three who are certified as eligible by the Virginia Department of Behavioral Health and Developmental Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.

OTHER COVERED SERVICES		
	In-Network Benefits Copayments/Coinsurance[2]	**Out-of-Network Benefits Copayments/Coinsurance[2]**
Home Health Care Skilled Services[7] **Pre-Authorization is required.[6]** Services are covered up to a maximum combined benefit with In-Network and Out-of-Network benefits of 100 visits per calendar year for Members who are home bound, and in the Plan's judgment require Home Health Skilled Services.[7] You will pay a separate outpatient therapy Copayment or Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient rehabilitation services Copayment or Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After Deductible Covered at 100%	After Deductible You Pay 50%
Hospice Care **Pre-Authorization is required.[6]**	After Deductible Covered at 100%	After Deductible You Pay 50%
Preventive Vision Services[7] Optima Health contracts with EyeMed Vision Services to administer this benefit. Coverage includes one examination every 12 months when done by a participating EyeMed Provider. To contact EyeMed about participating Providers call 1-888-610-2268.	Covered at 100% Contact lens examinations require the eye examination Copayment or Coinsurance plus the difference between the contact lens examination cost and the eyeglass examination cost. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit unless services are considered an Essential Health Benefit (EHB) for children.	For eye examinations from Out-of-Network Non-Plan Providers, Members will be reimbursed up to $30 for an eye examination only. Cost sharing amounts You pay for this benefit will not count toward Your Deductible or Maximum Out of Pocket Limit.
Telemedicine Telemedicine Services means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of treatment or service. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.

PRESCRIPTION DRUG BENEFIT	
Pharmacy Out-of-Pocket Maximum	**$2600 per individual/$5200 per family**
More information about **prescription drug coverage** is available at www.express-scripts.com. Insulin, syringes, and needles are covered under the Prescription Drug Benefit.	**For each prescription or refill:** Tier 1 - $10 Copayment Tier 2 - $30 Copayment Tier 3 – $60 Copayment Tier 4 – $60 Copayment **For Mail Order:** Tier 1 - $20 Copayment Tier 2 - $60 Copayment Tier 3 – $120 Copayment Tier 4 - $120 Copayment

NOTES

All benefits are subject to the terms and conditions in the *Summary Plan Document* (SPD). Words that are capitalized are defined terms listed in the Definitions section of the SPD.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This Plan does not have lifetime dollar limits on Your benefits. This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Optima Health has an internal claims appeal process, and an external appeal review process. Please look in Your SPD for details about how to file a complaint or an appeal.

Under certain circumstances Your coverage can be terminated. However, Your Coverage can only be rescinded for fraud or intentional misrepresentation of material fact. Please look in Your SPD in the section on When Your Coverage will end.

For Optima Health plans that require that You choose a Primary Care Provider (PCP) You have the right to choose any PCP who participates in our network and who is available to accept You or Your family members. For children, You may choose a pediatrician as the PCP.

1. **You or Your** means the Subscriber and each family member who is a Covered Person under the Plan.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's **Allowable Charge** for the Covered Service You receive.

   Allowable Charge is the amount Optima Health determines should be paid to a Provider for a Covered Service. When You use In-Network benefits from Plan Providers Allowable Charge is the Provider's contracted rate with Optima Health or the Provider's actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

   Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits. All other Covered Services received from Non-Plan Providers will be Covered under Your Out-of-Network benefits.

   When You use Out-of Network benefits from Non-Plan Providers Allowable Charge may be a negotiated rate; or if there is no negotiated rate Allowable Charge is Optima Health's In-Network contracted rate for the same service performed by the same type of Provider or the Provider's actual charge for the service, whichever is less. Non-Plan Providers may not accept this amount as payment in full.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out of Pocket Limit. Amounts applied to an Out-of-Network Deductible will apply toward the Plan's Out-of-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual member coverage Deductible before coverage begins. If You have family coverage You and Your family must satisfy the family coverage Deductible. This Plan has an embedded individual Deductible within the family Deductible. That means if one covered family member meets the individual member Deductible his or her benefits will begin. Once the total family coverage Deductible is met benefits are available for all covered family members. Amounts You are required to pay for preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Preventive Care Visits and Screenings You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles will not be reimbursed under the Plan. Any part of the calendar year Deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year.

4. **Maximum Out of Pocket Limit for In-Network Benefits** means the total dollar amount You pay out of pocket for most In-Network Covered Services during a calendar year. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's Out-of-Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your In-Network Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Copayments or Coinsurances or any other charges for the following will not count toward Your In-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Balance billing amounts from Non-Plan Providers;
    4. Premium amounts;
    5. Amounts You pay as a penalty for failure to comply with the Plan's Pre-Authorization procedures;
    6. Except for Emergency Services, amounts You pay for Out-of-Network Services;
    7. Cost Sharing amounts including Copayments, Coinsurance, and Deductibles for the following:
        i. Amounts You pay for Vision care unless services are considered an Essential Health Benefit (EHB) for children;
        ii. Amounts You pay for any benefits covered under a plan rider including riders for Vision Care and Materials unless services are considered an Essential Health Benefit (EHB) for children, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction unless services are considered an Essential Health Benefit (EHB) for children;

5. **Maximum Out of Pocket Limit for Out-of-Network Benefits** means the total dollar amount You will pay during a calendar year for most Out-of-Network Covered Services. Your Plan has a separate Maximum Out of Pocket Limit for Covered Services You receive under the Plan's In- Network Benefits. Deductibles, Copayments and Coinsurance amounts that You pay for most Out-of-Network Covered Services will count toward Your Out-of-Network Maximum Out of Pocket Limit. **If a service does not count toward Your Maximum Out of Pocket Limit You must continue to pay Your Copayments or Coinsurance for these services after Your Maximum Out of Pocket Limit has been met. Deductible, Copayments, Coinsurances, or any other charges for the following will not count toward Your Out-of-Network Maximum Out of Pocket Limit:**

    1. Amounts You pay for services or charges not covered under Your Plan;
    2. Amounts You pay for services after a benefit limit has been reached;
    3. Amounts You pay for In- Network Benefits;
    4. Amounts You pay for Vision care;
    5. Amounts You pay for any benefits covered under a plan rider including riders for Infertility Treatment, Vision Care and Materials, Hearing Aids, Oral Surgery/Wisdom Teeth Extraction,
    6. Amounts You pay as a penalty for failure to comply with the Plan's Pre-Authorization procedures;
    7. Amounts applied to Your In-Network Deductible;
    8. Balance billing amounts that exceed the Plan's Allowable Charge for a Covered Service from a Non-Plan Provider;
    9. Premium amounts

6. This benefit requires Pre Authorization before You receive services. Your benefits for Covered Services may be reduced or denied if You do not comply with the Plan's Pre-Authorization requirements. The Plan may also apply a penalty of up to $500 to any benefits paid for Covered Services if You do not comply with the Plan's Pre-Authorization requirements.

7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. Unless otherwise noted benefit limits are combined for services received both In-Network and Out-of-Network and for all places of service. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your In-Network or Out-of-Network Maximum Out of Pocket Maximum Limit.

8. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, Deductibles, Coinsurance factors, and Copayments that are no less favorable than for physical Illness generally. If the Plan charges a Global Copayment for prenatal, delivery, and postpartum services You are entitled to a refund from the Delivering Obstetrician if the total amount of the Global Copayment for prenatal, delivery, and postpartum services is more than the total Copayments You would have paid on a per visit or per procedure basis.

9. All Emergency, Urgent Care, Ambulance, and Emergency Behavioral Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. The Plan will reimburse a hospital emergency facility and provider, less Your applicable Copayments, Deductibles, or Coinsurance, for medical screening and stabilization services rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and related to the condition for which You presented in the hospital emergency facility. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had You received care from a Plan Provider

10. Preventive Care includes the services listed below. You may be responsible for an office visit Copayment or Coinsurance when You receive preventive care. Some services may be administered under Your prescription drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use it's normal medical care management processes to determine frequency and appropriate level of covered services under this benefit. Services covered under the Plan's outpatient prescription drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient prescription drug benefits. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

    1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force as of September 23, 2010, with respect to the individual involved;

    2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

    3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and

    4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:

    - **Breastfeeding support, supplies, and counseling in conjunction with each birth including:** comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
    - **Contraceptive Methods and Counseling including:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
    - **Screening and Counseling for domestic and interpersonal violence including** annual screening and counseling for all women.
    - **Gestational diabetes including** screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
    - **Human Immunodeficiency Virus (HIV) including** annual screening and counseling for sexually active women.
    - **Human Papillomavirus (HPV) DNA Test including:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
    - **Sexually Transmitted Infections (STI) including** annual counseling for sexually active women.
    - **Well-woman visits** to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

11. You do not need prior authorization from Optima Health or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Look in Your SPD in the Utilization Management Section for more information on Pre-Authorization.